ENCOUNTER FORM CHILDREN'S HOME VISIT PROGRAM

Date: _____ Client's Name: _____ DOB: _____ CHW: _____
Total Visit Time: _____ Visit Type: _____

≥12 years of age ASTHMA CONTROL (14 days)	WELL (1)	NOT WELL (2)	VERY POORLY (3)	COMMENTS
Days with symptoms	≤4 days	>4 days	daily	
Nights awakened with symptoms	≤1 days	2-7 times	8+	
Rescue medications use	≤4 days	>4 days	daily	
Interfere with activity	none	some	extreme	
Ages 5-11 ASTHMA CONTROL (14 days)	**WELL**	**NOT WELL**	**VERY POORLY**	**COMMENTS**
Days of symptoms	≤4 days	>4 days	daily	
Nights awakened with symptoms	≤1x/month	≥2x/month	≥2x/week	
Rescue medication use	≤4 days	>4 days	several x's/day	
Interference with activity	none	some	extreme	
Ages 0-4 ASTHMA CONTROL (14 days)	**WELL**	**NOT WELL**	**VERY POORLY**	**COMMENTS**
Days of symptoms	≤4 days	>4 days	daily	
Nights awakened with symptoms	≤1x/month	>1x/month	>1x/week	
Rescue medication use	≤4 days	>4 days	several x's/day	
Interference with activity	none	some	extreme	

COORDINATION OF CARE WITH HEALTHCARE SYSTEM/PROVIDER				
ACTIVITY SINCE LAST CHW VISIT	**Scheduled Provider visits**	**Un-scheduled Provider Visits**	**Asthma Hospitalizations**	**Asthma ER visits**
# of asthma related medical visits: (number)				
Next PC Visit Scheduled: (date)				
Other provider visit: (date)		Type of visit:		

ASTHMA MEDICATIONS REVIEW **Caution:** **If on Seravent control must be on an ICS (ex: flovent, Qvar, Pulmicort)**

Medications Review	Yes	No	Current Meds	Yes	No	Name
Medications was it talked about w/client			On a Controller			
DPI/MDI Technique correct			On a Rescuer			
Spacer used			Other Asthma Medicines			
Adherent to meds			Other Medicines			

ASTHMA ACTION PLAN						
Plan Type	**Yes**	**No**		**Yes**	**No**	**Comments**
Action Plan Given to Client			Action plan reviewed by CHW			
Completed action plan in home			Action plan used when needed			

PROBLEM LIST: Check "Yes" if it is a problem

Issue	Yes	Protocol	Comments	Issue	Yes	Protocol	Comments
1.Allergies-pollen/food				13. Mold		HE-5	
2. Cleaners/chemicals		HE-1		14. Provider Communication		HE-6	
3. Clinic attendance (for routine asthma care)		SM-6		15. Roaches		HE-7	
4. Depression		SM-7		16. Rodents		HE-8	
5. Dust/cleanliness		HE-2 & 9		17.Asthma Self-Management		SM1-4	
6. Dust Mites		HE-3		18. Tobacco		HE-4	
7. Fragrances/strong		HE-1		19. Ventilation		HE5	
8. Medication Adherence		SM-2		20. Worksite Triggers			
9. Medication Techniques		SM-9		21. Child/Elder Abuse		O-1&2	
10. Moisture		HE-5		22.Landlord/Tenant Issues Relocation		0-3	
11. Colds		SM-5		23. influenza		SM-8	
12. Wood smoke		HE-10		24. Pets		HE-6	

PROTOCOLS ADDRESSED: CHECK ALL PROTOCOLS COVERED DURING VISIT

Home Environment (HE)	Asthma Self-Management (SM) (Bolded protocols required for all participants)	Other (O)
❑ 1 -Assessing Household Products ❑ 2 -Dust Control ❑ 3 -Dust Mites ❑ 4 -Environmental Tobacco Smoke ❑ 5 -Mold & Moisture ❑ 6 -Pets & Asthma ❑ 7 -Roaches ❑ 8 -Rodents ❑ 9 -Using a Dust Mask ❑ 10 –Wood smoke	❑ **1 -Asthma Basics** ❑ **2 -Medication Adherence** ❑ **3 -Using an Asthma Action Plan** ❑ **4 -Warning Signs of Asthma** ❑ 5 -Colds and Asthma Care ❑ 6 -Communicating with Provider ❑ 7 -Depression ❑ 8 -Influenza and Flu Shots ❑ 9 -Inhalers and Spacers ❑ 10 -Peak Flow Monitoring ❑ 11 -Seeking Emergency Care ❑ 12 -What to Do During an Asthma Attack	❑ **1 -**Child Abuse and Mandatory Reporting ❑ **2 -**Adult/elder Abuse and Mandatory Reporting ❑ **3 -**Landlord Tenant Dispute Resolution ❑ **4 -**Relocation ❑ **5 -**Referrals _____ _____

PARTICIPANT ACTION PLAN

GOAL (no more than 3):

Barriers:

Actions:

Support:

Rewards for Success

<u>SOAP NOTES: optional</u>

- **Subjective**

- **Objective**

- **Assessment**

- **Plan**

Referrals made:

- **Supplies given: (check all given)**

__medicine box __green cleaning kit __spacer __peak flow meter __mattress/pillow casings (Size- Circle one: single, double, queen, king) __vacuum __ HEPA filter machine

COMMENTS: